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Milliman Client Report

Milliman

Kaiser Permanente Insurance Company (KPIC)

Small Group PPO 7/1/2011 Rate Filing
Actuarial Certification

Prepared for:
Kaiser Permanente Insurance Company

Prepared by:
Milliman, Inc.

Susan E. Pantely, FSA, MAAA
Consulting Actuary

650 California Street
17th Floor
San Francisco, CA 94108 USA

Tel +1 415 403 1333
Fax +1 415 403 1334

milliman.com

April 27, 2011

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ACTUARIAL MEMORANDUM

KAISER PERMANENTE INSURANCE COMPANY

SMALL GROUP PPO POLICY FILING

Qualifications

I, Susan E. Pantely, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. This actuarial certification is prepared on behalf of Kaiser Permanente Insurance Company (the "Company") to comply with California Insurance Code section 10181.6 (b) (2).

I am affiliated with Milliman, Inc. ("Milliman"), an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer or a trade association of health plans or insurers.

Scope

As a consulting actuary with Milliman, I have written this actuarial memorandum at the request of the Company to discuss the rate filing for its small group PPO policies. The proposed rates included in this filing will be effective for new and existing members enrolling or renewing on or after July 1, 2011. Rates are guaranteed for 12 months following the effective date or renewal date.

This statement of opinion complies with the Actuarial Standards of Practice 8 and 41, promulgated by the Actuarial Standards Board.

Reliance

I have relied upon information provided by Mr. Boris Shekhter, FSA, MAAA of Kaiser Foundation Health Plan. While I reviewed the information for reasonableness, I did not audit the underlying data for correctness. **Appendix A** contains Statement Regarding Accuracy and Completeness of the Underlying Data Sources provided to me as part of my review, and forms a part of this opinion.

Testing Procedures

As part of my review, I followed the testing procedures outlined in **Appendix B**.

Opinion – Actuarially Sound in the Aggregate

In my opinion, the proposed small group PPO premium rates for business in California are actuarially sound in the aggregate because the total of projected premium income, expected reinsurance recoveries, governmental risk adjustment cash flows, and investment income is adequate to provide for expected health benefit costs, settlement costs, marketing and administrative expenses, and cost of required capital as provided to me by the Company.

Opinion – Reasonable Premium Rate Increases

In my opinion, the proposed premium rate increases are reasonable. I based my opinion of reasonable rate increases on the factors below. The factors I considered were specifically required in Section A of the SB 1163 Guidance, titled "Unreasonable Rate Increases." The order of discussion below follows the order of factors listed in Section A of the SB 1163 Guidance. The assumptions, data used and other relevant information used in the rating filing development are included in **Appendix C**.

1. The annual premium rate increases by product are shown as **Appendix C-1**.

2. The choice of assumptions relating to per capita increases and other assumptions is reasonable.

3. The proposed rates result in rates between insured within similar risk categories that are permissible under applicable California law, and the premium differences correspond to differences in expected claims costs between allowable risk classes.

   Appendix C-2 shows member months, member dues, incurred claims, and loss ratios for the time period 1/1/2010 – 12/31/2010.

4. The premiums rate increase is the same for each premium rate and there are no changes in rating factors. Therefore, the premium rate increase is the same across risk categories and not overly burdensome on any particular group.

5. As stated above, in my opinion, the proposed small group PPO premium rates for business in California are actuarially sound. Therefore, the cumulative impact of the filed rate increases, combined with the previous increases, result in reasonable premium rates.

Factors Not Considered

Section A of the SB 1163 Guidance also listed the following items to review. I did not consider them in forming my opinion of a reasonable rate increase.

1. Due to low membership, the credible claims experience data is not available. Therefore, a reliable loss ratio cannot be projected.

2. Due to low membership, credible experience data for the prior three years is not available.

3. The company's rate of return, evaluated on a return-on-equity basis, for the prior three years and anticipated rate of return for the following year.

4. The company's employee and executive compensation.

   The employee and executive compensation is part of the overall administrative expense assumed in the premium development. I did not review the compensation levels of the staff or executives and offer no opinion on the appropriateness of the compensation levels.

5. The degree to which the rate increase exceeds the rate of medical cost inflation index.

   The proposed 12.0% annual premium rate increase is greater than the medical care component of the CPI for 2010 of 3.4%.

   While the proposed rate increase is larger than the medical costs index, material differences between the two measures provide an explanation as to the reasonability of the rate increase. The medical component of the CPI measure prices inflation at the retail level. That is, it measures the prices paid for a fixed market basket of medical goods and services. The medical CPI is a retrospective measure and does not account for expected future spending, which is the basis for premium rate setting.

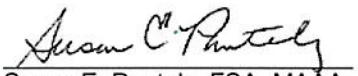
The following are examples of factors that are included in the premium rate increase that are not included in the CPI measure:

- Increased per capita utilization of services
- Cost for new technologies
- Changes in provider practice patterns or the intensity of the service being provided
- Changes in enrollment mix
- New mandated benefits
- Adverse selection
- Deductible leveraging effect
- Changes in provider mix and negotiated provider payment arrangement

6. The insurer's surplus condition and dividend history.

7. The nature and amount of transactions between the filing insurer and any affiliates over the prior three years.

Respectfully Submitted,



Susan E. Pantely, FSA, MAAA
Member of the American Academy of Actuaries
April 27, 2011

APPENDIX A
STATEMENT REGARDING ACCURACY AND COMPLETENESS OF THE UNDERLYING DATA SOURCES

Items Relied upon During Testing by Milliman:

- 2010 member dues, member months, and medical costs.
- July 2011 California small group proposed rate increases by PPO product.
- July 2011 California small group PPO Standard rates.

The sources identified above were relied upon by Milliman, Inc. in preparing this statement of actuarial opinion.

I, Boris Shekhter, hereby affirm that the data sources identified above, and attached to this statement, were prepared under my direction, and to the best of my knowledge are accurate and complete unless otherwise noted below.

4/27/11
Date

B. Shekhter
Signature

Boris Shekhter, FSA, MAAA
Actuarial Director
Kaiser Foundation Health Plan

APPENDIX B
DESCRIPTION OF TESTING PROCEDURES

1. Due to low membership, the experience data is not credible enough to develop premium rates. Therefore, I tested the reasonability of rates by performing an independent pricing of benefits for select plans based on the Milliman Health Cost Guidelines™ (HCGs).

   The Milliman HCGs provide a flexible but consistent basis for the determination of claim costs and premium rates for a wide variety of health benefit plans. The HCGs are a cooperative effort of all Milliman actuaries and represent a combination of their experience, judgment, and research. In most instances, cost assumptions are based on our evaluation of several data sources and not specifically attributable to a single source.

   Using the HCGs I estimated the required premium rates if the Kaiser benefit design was offered by a traditional commercial health plan that contracts with independent medical providers to provide services. My assumptions for average provider reimbursement and utilization levels were based on my experience with well managed PPO plans in the California market. The actual Kaiser premiums are lower than my estimated premium rates. Based on this, I concluded the rates are not excessive in the market.

   I also compared the PPO rates to Kaiser Foundation Health Plan's HMO and POS rates by adjusting for benefit differentials between the plans. The resulting rate relativities were reasonable based on benefit differentials and expected provider cost differences.

   I also reviewed the rate relativities by region and found them to be reasonable.

2. The information provided by KFIC was tested for reasonableness and consistency. Our testing included, but was not limited to, reconciling data from various reports and comparisons across time periods.

APPENDIX C-1
ANNUAL RATE INCREASE PERCENTAGE

The following exhibit shows the annual rate increase percentage included in the July 1, 2011 filing by product.

PLAN	JUL-11 OVER JUL-10
PPO 40/1000	12.0%
PPO 40/2500 with HSA	12.0%
KPCS PPO 30/500	12.0%
KPCS PPO 40/2200 with HSA	12.0%
KPCS OOA Indemnity 25/500	12.0%

APPENDIX C-2
EXPERIENCE VOLUME

The following exhibit shows member months, member dues, incurred claims, and loss ratio for the time period 1/1/2010 – 12/31/2010.

EXPERIENCE BY PRODUCT
CALENDAR YEAR 2010

	Member Months	Incurred Claims	Member Dues	Loss Ratio
PPO	7,459	$ 3,929,414	$ 3,619,473	108.6%
PPO HSA	1,050	996,165	462,551	215.4%
Choice Solutions PPO	966	253,150	627,723	40.3%
Choice Solutions HSA	160	527	104,748	0.4%
Choice Solutions Indemnity	3	0	2,909	0.0%
Total	9,638	$ 5,179,257	$ 4,817,404	107.5%